MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-P)

CERTIFICATE OF DEATH

★ C8682

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 52 Maryland Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Evelyn Brown Anderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Anderson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar - 20 - 1904

8. AGE:

Years	Months	Days	If less than one day
42	5	26	hrs. min.

9. Birthplace: Eastport Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Benjamin B. Brown

13. Birthplace: Maryland

MOTHER 14. Maiden name: Sarah E. Brangell

15. Birthplace: Maryland

16. Informant: Mrs Margaret Smit

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18-46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John W. Sayler Son

Address: Annapolis Md.

19. Sept 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1946, at 6 04 M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from September 10 1946 to Sept 15 1946 and that I last saw h.. alive on September 15 1946

	DURATION
Immediate cause of death: Peritonitis	3 days
Due to: Intestinal Obstruction	3 Days
Due to: Abdominal Adhesions	6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Abdominal adhesions Date of op. 9/1/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gilbert L. Anderson M.D. M. D. or other

Address: Annapolis Md Date signed 9/15/46.

C8683

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Riverside Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sherman Wiltins Ayres

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug. 24. 1935

8. AGE: Years	Months	Days	If less than one day
11	0	15	... hrs. ... min.

9. Birthplace: Oak Hall, Virginia (Town, county, and state)
10. Usual occupation: School
11. Industry or business: —
FATHER 12. Name: Edw. Sherman Ayres
FATHER 13. Birthplace: Means, Virginia
MOTHER 14. Maiden name: Emma Tull
MOTHER 15. Birthplace: Accomack, Virginia
16. Informant: Mr. Edw. S. Ayres
Address: 208 Riverside Rd. Brooklyn Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11-46 (month) (day) (year)
Cemetery or crematory: Greenwood Cemetery
Location: Temperance Virginia
18. Funeral director: Milton Schilling
Address: 3914 S. Hanover St
19. Sept 9 1946 (Date rec'd by registrar) Ida M. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1946, at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Sept. 8 1946

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-8-46
Where did injury occur? Brooklyn (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Branch of Patapsco River
Means of injury: Drowning Injured at work? no

23. SIGNATURE: John M. Cathey M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md. Date signed: 8-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

C8684

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ANNE ARUNDEL
City or town: Sylvan Shores, Riva, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #1, Box 247, Annapolis, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN BURTON EDWARD BAIN JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	baby

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1946

8. AGE: Years —; Months —; Days 5; If less than one day: ____ hrs. ____ min.

9. Birthplace: U.S.Naval Hospital, Annapolis, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John Burton Edward Bain
13. Birthplace: Belzoni, Miss.

MOTHER
14. Maiden name: Charlie Louise Collins
15. Birthplace: Baker County, Ga.

16. Informant: Hospital Records
Address: U.S.Naval Hospital, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19 46 (month) (day) (year)
Cemetery or crematory: Naval Cemetery
Location: Annapolis, Md.

18. Funeral director: B. H. Kopping & Son
Address: Annapolis, Md.

19. Sept. 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1946 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/12/46 19 ____ to 9/17/46 19 ____ and that I last saw him alive on 9/17/46 19 ____

Immediate cause of death	DURATION
Cardiac and respiratory failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: R. Nathaniel Bunch, Jr. M.D.
M. D. or other
Address: U. S. NAVAL HOSPITAL, Annapolis, Md. Date signed: 9/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 08685 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Meade U.S.A. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred: Post Refrigeration Plant - Ft. Geo. G. Meade

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 4821 Park Heights Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CLINTON THEODORE BARNHART

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Sadie Barnhart

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	26	hrs. min.

9. Birthplace: Westminster, Md (Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business:

FATHER — 12. Name: John A. Barnhart

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary C. Stevens

15. Birthplace: Maryland

18. Informant: Personnel Center

Address: Ft. Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 15, 1946 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Greenmount Carroll Co Md

18. Funeral director: Lorin Byers

Address: 5005 Park Heights Ave Balto

19. 9/14/46 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1946, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 to 19

and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Cardiac failure	
Due to: Coronary Thrombosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? Cutting M.E.

23. SIGNATURE: Edward P. Ritchings M.D. M. D. or other

Address: Annapolis, Md. Date signed: 13 Sept. 46

Dr. Clapp.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

68686

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: 72 Cathedral St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Thomas Belt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Helen Belt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1902

8. AGE: Years	Months	Days	If less than one day
43	8	29	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: U.S. Naval Academy.
FATHER 12. Name: Thomas Belt
13. Birthplace: Md.
MOTHER 14. Maiden name: Hannie Anderson
15. Birthplace: Md.
16. Informant: Helen Belt
Address: 141 Southe St. Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1946 (month) (day) (year)
Cemetery or crematory: Brewers Hill
Location: Annapolis, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis Md.
19. Sept. 27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23, 1946, at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Sept. 23, 1946

	DURATION
Immediate cause of death: Coronary embolism	Sudden
Due to: Coronary Thrombosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Clapp M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 9/25/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-a)

CERTIFICATE OF DEATH

8687

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Emergency Hospt.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Blanche Georgia Bull

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lem B. Bull
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jany 26 1894
8. AGE: Years: 52 Months: 7 Days: 30 If less than one day: hrs. min.
9. Birthplace: Tennessee (Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: William Carmichel
13. Birthplace: Tennessee
MOTHER 14. Maiden name: Mary Langford
15. Birthplace: Tennessee
16. Informant: Lem B. Bull
Address: Gambrills A A Co Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27 1946 (month) (day) (year)
Cemetery or crematory: Church of God
Location: Gambrills A A Co Md
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Sept. 27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1946 at 4 15 D M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 1946 to Sept. 24 1946
and that I last saw h. or alive on Sept. 24 1946

	DURATION
Immediate cause of death: Auricular Fibrillation	10 days
Due to: Aortic and mitral	3 1/2 years or more
Due to: regurgitation	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Claffey M.D. M. D. or other
Address: Annapolis Md Date signed 9/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

C8688

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

204 Clay St.

How long in hospital or institution? xxxxxxxxxxxxxxxxxx

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Clay St.

(If rural, give LOCATION)

2.(a) If veteran, name war xxxxxxxxxxxxxxxxxx

3.(a) FULL NAME: Mattie Byrd

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Lentullus Byrd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1888

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace: Charlottsville Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknow

MOTHER — 15. Birthplace: Virginia

16. Informant: Lentullus Byrd

Address: 204 Clay St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-1946 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St Extd. Annapolis Md.

18. Funeral director: Mrs Chas. E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Sept 7, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-4-46, 19..., at 5 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-4-46, 19... to 9-4-46, 19...

and that I last saw her alive on 9-4-46, 19...

Immediate cause of death	DURATION
Encephalopathy	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. T. Allen M. D. or other

Address: 14 Arnold St Date signed: 9-5-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 22

8689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Harmans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day.
Hospital, institution, or street address where death occurred: Gilbert Clark Farm.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henrietta Cager.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widow.

6.(b) Name of husband or wife: Thomas Cager.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 24th 1877

8. AGE: Years 68 | Months 10 | Days 22 | If less than one day: hrs. min.

9. Birthplace: A. A. Co., Md.
(Town, county, and state)

10. Usual occupation: Domestic.

11. Industry or business: Caleb Briggs

FATHER
12. Name: P. H. Cager
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza Barnes
15. Birthplace: Howard Co., Md.

16. Informant: Clarence Hamilton
Address: Hanover, Md. R. + D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/46. (month) (day) (year)
Cemetery or crematory: St. Rest - St. Mark's Ch.
Location: Harmans, Md.

18. Funeral director: Kate + Clarence Williams
Address: 322 N. Fremont St., Balto., Md.

19. Sept 18 1946 (Date rec'd by registrar) Edna Haskell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15th 1946 at 10 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 14th 1946 to Sept. 15th 1946 and that I last saw h-er alive on Sept. 12th 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	10 min
Due to: Hypertensive Cardio-vascular disease	7 mos.
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M. D.
M. D. or other
Address Savage Date signed 9/17/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

C8690

Reg. Dist. No. 204

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 years 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Robert Weston Carrick

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 1 1871

8. AGE: Years	Months	Days	If less than one day
74	10	5	hrs. min.

9. Birthplace: Davidsonville Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Benjamin F. Carrick
13. Birthplace: Davidsonville Md.

MOTHER
14. Maiden name: Mary A. Lewis
15. Birthplace: Davidsonville Md

16. Informant: Frank Carrick
Address: 7 High St Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept 10-1946
(month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md

18. Funeral director: W. C. Sandifer & Son
Address: Galesville Md.

19. Sept 9 1946 Edward Collemer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1946, at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to Sept 6 1946
and that I last saw him alive on Sept 5 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Kavanaugh MD
M. D. or other
Address: 31 Southgate Ave Date signed: 9-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

State Street

1201 West

32 47

1104.2 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08691

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 fourth Ave. South

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth O. Cofran

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George W. Cofran

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1866

8. AGE: Years	Months	Days	If less than one day
80	4	19	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Confectionery store

11. Industry or business: Own business

FATHER

12. Name: Gustave A Lotze

13. Birthplace: Sweden

MOTHER

14. Maiden name: Bertha Moller

15. Birthplace: Sweden

18. Informant: Gustave A. Lotze

Address: Glen Burnie, Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1946 (month) (day) (year)

Cemetery or crematory: Louden Park

Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Sept. 3 1946 (Date rec'd by registrar) M. Seabra Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 1946, at 3:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1946, to Sept 2 1946

and that I last saw h.. alive on Sept 1. 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Cardio. Vascular Renal	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James S. Bellingola M. D. M. D. or other

Address: Glen Burnie, Md. Date signed: Sept 3, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

08692

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Marley

(If ontside city or town limits, write RURAL snd give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ruth V. Coleman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: William J. Coleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8 - 1912

8. AGE:	Years	Months	Days	If less than one day
	34	6	1	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Chas Hartman

13. Birthplace: Md

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Md

16. Informant: Mr. William J. Coleman

Address: Marley Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-46 (month) (day) (year)

Cemetery or crematory: Loudon Park.

Location: Baltimore Md

18. Funeral director: Geo L. Bergen Jr

Address: 1512 Hollins St

19. 9/12 1946 (Date received by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1946, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 1946, to 9/9/46 1946

and that I last saw h alive on 9/9/46 1946

	DURATION
Immediate cause of death: Diabetes Mellitus	Several years
Due to: Hypertension	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please onderline the canse to which death shonld be cbarged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (Conuty) (State)

Injured at home, farm, industry, public place (where?)

Meene of injury: Injured at work?

23. SIGNATURE: Gertrude H. Pardee M.D. M. D. or other

Address: Glen Burnie. Md. Date signed 9/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167a)

CERTIFICATE OF DEATH

68693 P

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month - 6 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month - 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1322 Druid Hill Avenue, Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME

CORNISH - BETTY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	?

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years	Months	Days	If less than one day
80	?	?	..... hrs. ..... min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER
12. Name: ?
13. Birthplace

MOTHER
14. Maiden name: ?
15. Birthplace

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-25-46 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location: Balto Maryland

18. Funeral director: Mrs. L. R. Williams

Address: 322 S Schroeder St

19. 9/23/46 (Date rec'd by registrar) 19 ..... A. W. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1946, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16, 1946, to September 21, 1946 and that I last saw her alive on September 21, 1946

Immediate cause of death	DURATION
Senile Psychosis	Known since admission
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Albert V. Sonderegger M. D. or other

Address: Crownsville, Maryland Date signed 9/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

P 24

08694

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Pasadena. Md — (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 year.
Hospital, institution, or street address where death occurred: No
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: near Pasadena. Md. (Rural) (If outside city or town limits, write RURAL and give nearest town)
Street No. .... (If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Laura Maud Coward.

3. (b) Social Security Number: Non

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Married.

6.(b) Name of husband or wife: George W. Coward. Sr
6.(c) If alive, give age .... years: 70

7. Birth date of deceased (mo., day, yr.): Oct 17, 1872

8. AGE: Years	Months	Days	If less than one day
73	11	8	— hrs. .... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: House wife.
11. Industry or business: at Home.

FATHER
12. Name: Hugh Roberts
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Emily Mahaney.
15. Birthplace: Balto. Md.

16. Informant: Geo. W. Coward. Sr
Address: Pasadena. Md RFD

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 9/28/46 (month) (day) (year)
Cemetery or crematory: London Park.
Location: Baltimore, Md.
18. Funeral director: H. G. Lickner & Son
Address: Baltimore Md

19. 9-26-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1946, at 10:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Sept 25 1946 and that I last saw h.. alive on Sept. 24 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Cardio. Vascular Disease	5 years
Due to: Toxic Thyroid.	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Toxic Thyroid — Date of op. 1937
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: James S. Bielingola M.D. (M. D. or other)
Address: Glen Burnie. Md Date signed Sept. 25, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

68695

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Dean
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I and II

3.(a) FULL NAME: Percy (n) Cranford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ella Cranford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9 October 1886

8. AGE: Years	Months	Days	If less than one day
59	11	20	..... hrs. ..... min.

9. Birthplace: Anne Arundel (Town, county, and state)
10. Usual occupation: U.S. Navy (Retired Inactive)
11. Industry or business: Ret. USN

FATHER
12. Name: James Cranford
13. Birthplace: Anne Arundel County

MOTHER
14. Maiden name: Mary Griffen
15. Birthplace: Maryland

16. Informant: Mrs. Ella Cranford (Wife)
Address: 5 Dean St., Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2/46 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: annapolis md.

18. Funeral director: [illegible] & Son
Address: annapolis, md.

19. Oct. 2 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 September 1946, at 7:49 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 September 1946, to 29 Sept. 1946 and that I last saw him alive on 29 September 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	10 min.
Due to: Coronary Thrombosis	19 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R.H. PARKER, Comdr., (MC), USN (M. D. or other)
Address: U.S. Naval Hospital, Annapolis, Maryland Date signed: 9-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C8696

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mnnth, 1 day

Hospital, institution, or street address where death occurred:
Crownsville, State Hospital

How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 319 North Carey Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: DATCHER - ISAAC

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Pearl Datcher, 319 North Carey St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE:

Years	Months	Days	If less than one day
40	unknown		--- hrs. --- min.

9. Birthplace: Alabama
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Isaac Datcher
13. Birthplace: Alabama

MOTHER
14. Maiden name: Lula Baker
15. Birthplace: Alabama

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Sept. 18 1946 (month) (day) (year)
Cemetery or crematory: M.F. Calvary Cem.
Location:

18. Funeral director: Mrs. Katie R. Williams
Address: 322 W. Lafayette St.

19. 9-18-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 19 46, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 19 46, to Sept. 13 19 46 and that I last saw h... im alive on September 13 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 8/12/46
Due to: -----	
Due to: -----	
Other conditions: -----	

(Include pregnancy within 3 months of death) -------

Major findings of operations: ----- Date of op.: -----

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -----
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: --------- Injured at work? -------

23. SIGNATURE: Albert J. Ahrbrood M. D. or other
Address: Crownsville, Maryland Date signed: 9/13/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

C8697

Reg. Diat. No. 38 28

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Sherwood Forest

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

in Severn River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Sherwood Forest

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Domhoff

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 10th 1916

8. AGE:

Years	Months	Days	If less than one day
30	6	21	... hrs. ... min.

9. Birthplace: Pittsburgh Pa. (Town, county, and state)

10. Usual occupation: in lumber business

11. Industry or business

FATHER

12. Name: Harry Frederick Domhoff

13. Birthplace: Pittsburgh Pa

MOTHER

14. Maiden name: Harriett Agnes Druendish

15. Birthplace: Pittsburgh Pa

16. Informant: Mrs. John H. Neely

Address: 6336 Jackson St. Pittsburgh Pa

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1946 (month) (day) (year)

Cemetery or crematory: Pittsburgh Pa.

Location: Pittsburgh Pa.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Maryland

19. 9/6 1946 E. F. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 1946 at about 5 P. M.

21. I CERTIFY that death occurred on the date above stated. Post mortem Examination

Immediate cause of death: Drowning — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 9/3/46

Where did injury occur? near Sherwood Forest, A. A., Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Severn River

Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Catley M.D. Deputy medical Examiner (M. D. or other)

Address: Annapolis, Maryland Date signed: 9/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C8698 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month - 7 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 month - 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1408 Mosher Street, Baltimore, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: DORSEY - MOSES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs. Ida Dorsey

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): ~~XXXXXXX~~ ~~Unknown~~ ~~XXXXXX~~ March 7, 1896

8. AGE: Years: ~~XXX XXXX~~ ~~Unknown~~ 50 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: .....

FATHER 12. Name: Unknown

FATHER 13. Birthplace: "

MOTHER 14. Maiden name: "

MOTHER 15. Birthplace: "

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/46 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore

18. Funeral director: Geo. G. Kelso

Address: 1323 Eastern Street

19. 9/4/46 (Date rec'd by registrar) 19..... A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2, 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1946, to September 2, 1946 and that I last saw him alive on September 2, 1946

	DURATION
Immediate cause of death: General Paresis	Known since Admission
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Herbert J. Stinebeck, M. D. or other

Address: Crownsville, Maryland Date signed: 9/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08699

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 6 mos, 3 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr, 6 mos, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1213 W. Mulberry Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DOUGLAS - MILDRED

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	unknown

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1915?

8. AGE: Years	Months	Days	If less than one day
31?	unknown		---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: -----

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 7 46 (month) (day) (year)
Cemetery or crematory:
Location: Charlotte North Carolina

18. Funeral director: Isaac L Brown Son
Address: 1086 Montgomery St

19. 9/7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1946 at 2:33 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1945 to Sept. 6 1946 and that I last saw her alive on September 6 1946

Immediate cause of death	DURATION
General Paresis	Known to us since 3/3/45
Due to: -----	
Due to: -----	
Other conditions: ----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: -----
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 9/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

68700

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ned Butt Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter B. Edelen

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances W. Edelen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 16-1897

8. AGE:

Years	Months	Days	If less than one day
49	2	19	..... hrs. ..... min.

9. Birthplace: Prince George Co. Md
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: St. Roads Comm.
FATHER 12. Name: Reinelda Edelen
13. Birthplace: Md
MOTHER 14. Maiden name: Unknown
15. Birthplace: Md
16. Informant: Mrs Frances W. Edelen
Address: Severn Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9-1946 (month) (day) (year)
Cemetery or crematory: Glen Haven Park
Location: Glen Burnie Md
18. Funeral director: J. W. Singleton
Address: Glen Burnie Md
19. Sept 6 1946 (Date rec'd by registrar) Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1946, at 6.7 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 24 1946, to Sept. 5 1946
and that I last saw him alive on Sept. 5 1946

Immediate cause of death	DURATION
Cardio-Vascular Dis.	5 days.
Due to	
Due to	
Other conditions: Hypertension	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bare Jr. M.D. M. D. or other
Address: Linthicum Date signed: 9-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08701 P

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 10 months, 26 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs, 10 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 633 Mosher Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: ENNIS - ELLA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years	Months	Days	If less than one day
73	unknown		--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ------

FATHER
12. Name: Charles Ennis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 25, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City

18. Funeral director: Joseph A. Lively
Address: 661 W. Barre St., Balto., Md.

19. 9-23 19 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 19 46, at 11:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22 19 43, to Sept. 18 19 46 and that I last saw h---er alive on September 18 19 46

Immediate cause of death	DURATION
Tabo-Paresis	Known to us since 10/22/43
Due to: -----	
Due to: -----	
Other conditions: ----	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: -----

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------- Injured at work? -------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 9/18/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08702

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 628 Jasper Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: FLETCHER - SAMUEL

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Bessie Fletcher, 628 Jasper St., Balto., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1903

8. AGE: Years	Months	Days	If less than one day
43	unknown		——— hrs. ——— min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER — 12. Name: Junious Rodney
FATHER — 13. Birthplace: Alabama
MOTHER — 14. Maiden name: Missouri Grills
MOTHER — 15. Birthplace: unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-14-46 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location: Balto Md
18. Funeral director: Mr Frances A Hemsley
Address: 718 N Biddle St
19. Sept 17 1946 E.T. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1946 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946 to Sept. 11 1946 and that I last saw him alive on September 11 1946

	DURATION
Immediate cause of death: General Paresis	Known to us since 7/17/46
Due to: ———	
Due to: ———	
Other conditions: ———	

(Include pregnancy within 3 months of death)

Major findings of operation: ——— Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did Injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of Injury: ——— Injured at work? ———

23. SIGNATURE: Herbert S. Hinebaugh M. D. or other
Address: Crownsville, Maryland Date signed: 9/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for addition of approximate age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

FILM No. I 07 OCT 8 1946

08703 ★ Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months - 1 day

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 months - 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 427 North Pine Street, Baltimore

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRAZIER - GEORGIA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Howard Frazier

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Approx. Unknown 66			hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: "

15. Birthplace: "

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal, Which?) Date thereof 9/9/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt. Hospital

Address: Crownsville

19. Sept 9 1946 (Date rec'd by registrar) E. Jayne Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2, 1946 at 8:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12, 1946 to September 2, 1946 and that I last saw her alive on September 2, 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since February 12, 1946
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since Feb. 12, 1946

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Pinkerton M. D. or other

Address: Crownsville, Maryland Date signed: 9/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08704

Reg. Dist. No. 3

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 647 W. Conway Street, Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FUNN - ARMSTEAD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2/27/1896?

8. AGE: Years	Months	Days	If less than one day
50 ?			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: ?
11. Industry or business:

FATHER
12. Name: ? Jesse Funn
13. Birthplace: ? Va.

MOTHER
14. Maiden name: (Kashrin) Katherine Cox
15. Birthplace: ? Va.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24-1946 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location:

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. 9/23/46 (Date rec'd by registrar) 19 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20, 1946, at 6:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13, 1946, to September 20, 1946
and that I last saw him alive on September 20, 1946

Immediate cause of death: General Paresis — DURATION: Known to us since 9/13/46
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hart J. Armstrong M. D. or other
Address: Crownsville, Maryland Date signed: 9/21/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

08705

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Murray Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin Collison Pott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth L. Pott
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 20th 1866

8. AGE: Years	Months	Days	If less than one day
80	4	23	..... hrs. ..... min.

9. Birthplace: Montgomery Co. Md.
(Town, county, and state)
10. Usual occupation: Major on Adjutant Generals
11. Industry or business: Office of Stat of Maryland

FATHER
12. Name: Benj C. Pott
13. Birthplace: Montgomery Co. Md.

MOTHER
14. Maiden name: Rebecca Crozel
15. Birthplace: Montgomery Co Md.

16. Informant: Richard V. Pott
Address: 22 Murray Ave Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14th 1946 (month) (day) (year)
Cemetery or crematory: Monocacy Cemetery
Location: Poolesville, Md.

18. Funeral director: John M. Saylor & Son
Address: Annapolis Md.

19. Sept. 13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1946 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1946 to Sept 12 1946
and that I last saw him alive on September 12 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to Arterial Hypertension	Several yrs
Due to Arterio Sclerosis	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Furnas M. D. or other
Address: Annapolis, Md. Date signed 9/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

08706

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Gambrills, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Poplar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARD ALVA GOTT

3.(b) Social Security Number: 217-05-2329

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~Single~~ married

6.(b) Name of husband or wife: Dorothy Louise Gott

Nee Howard 6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): December 16, 1914

8. AGE: Years	Months	Days	If less than one day
31	8	25	....hrs. ....min.

9. Birthplace: Springfield, Missouri. (Town, county, and state)

10. Usual occupation: Chauefeur

11. Industry or business: Dave Husler, (Gambrills Md)

FATHER 12. Name: Arthur Albert Gott

13. Birthplace: Dallas Co. Missouri

MOTHER 14. Maiden name: Lula Creek

15. Birthplace: Dallas Co. Missouri

16. Informant: Mrs. Joseph Howard

Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13, 46 (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Thomas W. Dingatow

18. Funeral director: Glen Burnie, Md.

Address

19. Sept 13 1946 (Date rec'd by registrar) M. M. Dalba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1946, at 2.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.... to — 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Accidental Burns	instantly
Due to	
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes; fill in the following:

Accident, suicide, or homicide: Accident Date of 9/11/46

Where did injury occur? Gambrills (City or town) A. A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Home burned Injured at work? No

23. SIGNATURE: Everett A. Pinkerton M. D. or other

Address: Glen Burnie Md. Date signed: 9/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

08707

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Poplar Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: SHARON LEE GOTT

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ----------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 13, 1942

8. AGE: Years	Months	Days	If less than one day
4	0	28	..... hrs. ..... min.

9. Birthplace: Gambrills, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Richard Alva Gott

13. Birthplace: Springfield, Missouri

MOTHER 14. Maiden name: Dorothy Louise Howard

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Joseph Howard

Address: Gambrills, Md.

17. Birial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 46 (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Gambrills, Md.

16. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Sept 13 19 46 (Date rec'd by registrar) Mcsalba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 46, at 2.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental Burns	Instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/11/46

Where did injury occur? Gambrills (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE: Gustave N. Pancoast M.D. M. D. or other

Address: Glen Burnie Md. Date signed 9-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

08708

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Gambrills, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Poplar Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Richard Gott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 18, 1940

8. AGE: Years	Months	Days	If less than one day
5	10	23	hrs. min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Richard Alva Gott

FATHER — 13. Birthplace: Springfield, Missouri

MOTHER — 14. Maiden name: Dorothy Louise Howard

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Joseph Howard

Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13, 46 (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Gambrills, Md.

18. Funeral director: Thomas W. Simpson

Address: Glen Burnie, Md.

19. Sept 13, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 1946, at 2.00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——, 19—— to ——, 19——

and that I last saw h— alive on ——, 19——

Immediate cause of death	DURATION
accidental Burns	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/11/46

Where did injury occur? Gambrills (City or town) A.A. (County) Md. (State)

Injured at home, farm, Industry, public place (where?): Home

Means of injury: Home burned - Injured at work? No

23. SIGNATURE: Gertrude F. Pemberton M. D. or other

Address: Glen Burnie Md Date signed: 9/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08709

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Months

Hospital, Institution, or street address where death occurred: Severn, river nr North Severn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County:

City or town: Gainsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: GREEN: Johnnie (n) Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Dorthy Mae GREEN

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): 20 March 1925

8. AGE: Years	Months	Days	If less than one day
21	5	15	hrs. min.

9. Birthplace: Lakeland, Florida
(Town, county, and state)

10. Usual occupation: St M 1/c

11. Industry or business: USN

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Catherine Fleming
15. Birthplace: unknown

16. Informant: U.S. Naval Health Record

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 6-46 (month) (day) (year)

Cemetery or crematory

Location: Gainsville, Florida

18. Funeral director: Ben L. Hopping & Son

Address: 170-172 West St. Annapolis, Md.

19. Sept. 6 19 46 (Date rec'd by registrar) W. Donnell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 Sept. 19 46 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination Sept. 5 19 46

Immediate cause of death: Drowning

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 9-4-46

Where did injury occur? near Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Severn River

Means of injury: Fell overboard Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis, Maryland Date signed: 9-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

08710

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several years
Hospital, institution, or street address where death occurred: near Carr's Wharf Rhode River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 912 Monroe
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Gustav Greve

3.(b) Social Security Number: 219-12-3568

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Elizabeth P. Greve
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): April 22 - 1924

8. AGE:

Years	Months	Days	If less than one day
22	6	5	...hrs. ...min.

9. Birthplace: Balto md
(Town, county, and state)
10. Usual occupation: apprentice Lineman
11. Industry or business: Gas & Electric Co

FATHER
12. Name: Geo E Greve
13. Birthplace: Germany

MOTHER
14. Maiden name: Gertrude Graubaum
15. Birthplace: Germany

16. Informant: Elizabeth P. Greve
Address: 912 monroe St Eastport md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 1/46 (month) (day) (year)
Cemetery or crematory: U.S. National
Location: annapolis - Md.
18. Funeral director: Geo. E. Topping & Son
Address: annapolis Maryland

19. Sept. 30 1946 (Date rec'd by registrar) Edmund Collenson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 1946 at 2 30 P. M

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post mortem Examination ~~[illegible]~~ Sept. 27 1946

Immediate cause of death	DURATION
Electrocution	
Due to: Accidental	
Due to: (2400 volts.)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 9/27/46
Where did injury occur? Mayo (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Carrs Wharf Rd. Rd
Means of injury 2400 volts electricity Injured at work? yes

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Coroner
Address: Annapolis - Date signed 9/27/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08711

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months - 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 9 months - 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 545 W. Hoffman Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GROSS - HOWARD EDWARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1923

8. AGE: Years	Months	Days	If less than one day
23			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Porter
11. Industry or business:

FATHER
12. Name: Lawrence Gross
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto
18. Funeral director: Mrs. Kate R. William
Address: 322 N. Schroeder Street
19. 9/5/46 (Date rec'd by registrar) 19 A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 1946 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27, 1945 to September 3, 1946 and that I last saw him alive on September 3, 1946

	DURATION
Immediate cause of death: General Paresis	Known since admission
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert J. Thompson M. D. or other
Address: Crownsville, Maryland Date signed: 9/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08712

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 916 Poplar St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Anna Belle ~~Mary~~ S. Hagelin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1946

8. AGE: Years | Months | Days | If less than one day: 3 hrs. ..... min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Carl Hagelin

FATHER — 13. Birthplace: Annapolis Md.

MOTHER — 14. Maiden name: Anna Pryor

MOTHER — 15. Birthplace: Elkton Md.

16. Informant: Carl Hagelin

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16th 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md.

19. Sept. 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14, 1946 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1946 to Sept 14 1946

and that I last saw her alive on Sept 14, 1946

Immediate cause of death	DURATION
Prematurity (4½ month)	30 m.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James R. Martin, M.D. M. D. or other

Address: 165 Prince George St. Annapolis, Md. Date signed 9-15-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

CERTIFICATE OF DEATH

08713

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 42 Northwest St.

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Northwest Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emma Lillian Harris

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Harris

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): March 13, 1887

8. AGE: Years	Months	Days	If less than one day
59	5	27	....hrs. ....min.

9. Birthplace: Annapolis, Md.

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: None

FATHER

12. Name: William Parker

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Reed

15. Birthplace: Annapolis, Md.

16. Informant: Constantia Adams

Address: 42 Northwest Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-13-46 (month) (day) (year)

Cemetery or cremetory: Brewer Hill

Location: West Street

19. Funeral director: Ethel L. Hicks

Address: 43-45 Northwest Street

19. Sept. 13 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9, 1946, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946, to Sept 9, 1946 and that I last saw h.. alive on Sept 9, 1946

Immediate cause of death	DURATION
a. Carcinoma of Stomach	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Theodore G. Johnson M.D. M. D. or other

Address: 40 Northwest Street Date signed 9/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08714

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 2 mos, 6 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 yrs, 2 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1349 North Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: HARRIS - ROGER (Charles Brown)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ella Harris, 1349 N. Fremont Ave., Balto., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1892?

8. AGE: Years	Months	Days	If less than one day
54?	unknown		---- hrs. ---- min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: Tony Harris
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Lenser
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12-46 (month) (day) (year)
Cemetery or crematory: St. Peter
Location: Baltimore City
18. Funeral director: Geo. G. Kellom
Address: 1303 Presstman, St.

19. 9/11/46 (Date rec'd by registrar) 19.... A. W. Jessup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1946 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1944 to Sept. 9 1946 and that I last saw him alive on September 9 1946

Immediate cause of death: General Paresis — DURATION: Known to us since 7/3/44
Due to: -----
Due to: -----
Other conditions: -----
(Include pregnancy within 3 months of death)

Major findings of operations: ----- Date of op. -----
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of -----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed 9/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 08716

1. PLACE OF DEATH:
County: ANNE ARUNDEL COUNTY
City or town: FERNDALE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 MONTHS
Hospital, institution, or street address where death occurred: 205 WICKLOW RD.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1116 S. Potomac St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES EDWIN HELM

3.(b) Social Security Number: 214-05-3097

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife: KATE R. HELM.
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): MAY 30, 1873

8. AGE: Years	Months	Days	If less than one day
73	3	22	... hrs. ... min.

9. Birthplace: BALTIMORE (Town, county, and state)
10. Usual occupation: NIGHT WATCHMAN
11. Industry or business: American Hammer & Piston Ring Co.

FATHER
12. Name: Joseph Helm
13. Birthplace: Balto., Md.

MOTHER
14. Maiden name: Virginia Diamond
15. Birthplace: Balto., Md.

16. Informant: MR. WILLIAM HELM
Address: 205 WICKLOW RD. FERNDALE MD.

17. Burial (Burial, cremation, or removal) Date thereof 9/25/46 (month) (day) (year)
Cemetery or crematory: ~~Loudon Park~~ Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 9/23/46 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 22, 1946, at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 26 1946, to SEPT. 22 1946, and that I last saw h. I.M. alive on SEPT 22 1946.

Immediate cause of death	DURATION
PULMONARY EDEMA.	
Due to CARDIAC FAILURE	
Due to AURICULAR-VENTRICULAR HEART BLOCK	
Other conditions ARTERIOSCLEROTIC HEART DISEASE.	

(Include pregnancy within 3 months of death)

Major findings of operations: NO OPERATION
Date of op. ...
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Henry Zugan M. D. or other
Address: Glen Burnie Date signed 9-23, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08717

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 7 mos, 5 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 yrs, 7 mos, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)

State: Maryland County: -----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME

JACKSON - IRENE (Johnson)

3. (b) Social Security Number -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1911?

8. AGE: Years	Months	Days	If less than one day
35?		unknown	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER
12. Name: Henry Dogley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bertha ?
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8-46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Duff Hospital

Address

19. Sept-9-1946 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1946 at 2:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1944, to Sept. 6 1946 and that I last saw her alive on September 6 1946

Immediate cause of death	DURATION
Cardiorenal Disease	Known to us since 1/31/44
Due to: -----	
Due to: -----	
Other conditions: Mental Deficiency	Known to us since 1/31/44

(Include pregnancy within 3 months of death)

Major findings of operations: ----- Date of op. -----

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE: Wm. J. Armstrong M. D. or other

Address: Crownsville, Maryland Date signed 9/6/46.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

08718

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 239 Hanover St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jeannette Jennings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20 1875

8. AGE: Years 71 | Months 3 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Mose Jennings
13. Birthplace A A Co Md

MOTHER 14. Maiden name Harriett Brown
15. Birthplace A A Co Md

16. Informant Rachel Jennings
Address 239 Hanover St. Annapolis Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 26-1946 (month) (day) (year)

Cemetery or crematory St Mary's
Location Annapolis Md
18. Funeral director John M Taylor Son
Address Annapolis Md.

19. Sept 23 1946 (Date rec'd by registrar) W Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1946, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1946, to Sept. 19 1946 and that I last saw her alive on Sept. 19. 1946

Immediate cause of death	DURATION
Carcinoma of Rectum	Unknown
Arterial Hypertension	3 years
Due to Chronic myocarditis	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M. D.
M. D. or other
Address Annapolis, Md. Date signed 9/23/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

(1) MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

08719

FILM No. I 08 NOV - 7 1946

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 40 College Creek Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alvin Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1919

8. AGE: Years	Months	Days	If less than one day
26	9		hrs. min.

9. Birthplace Annapolis, A. A Co. Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name William Johnson

13. Birthplace Md.

MOTHER 14. Maiden name Mary Calvert

15. Birthplace Md.

18. Informant Herbert Johnson

Address 40 College Creek Terrace Ann. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1946 (month) (day) (year)

Cemetery or crematory Bowers Hill

Location Annapolis Md.

18. Funeral director J. E. Johnson

Address Annapolis Md.

19. Sept. 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to Sept 4 1946

and that I last saw him alive on Sept 4 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4-5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. Kilcran M.D. M. D. for other

Address 31 Southgate Ave. Date signed 9/3/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08720

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 75 Water Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: JOHNSON - EDNA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): January 2, 1925

8. AGE: Years	Months	Days	If less than one day
21	8	12	——— hrs. ——— min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ———

FATHER
12. Name: Tim Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude Jones
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19 1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J. B. Johnson

Address: Annapolis

19. Sept. 17, 1946 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1946 to Sept. 14 1946 and that I last saw her alive on September 14 1946

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 8/21/46
Due to: ———	
Due to: ———	
Other conditions: Psychosis with Infectious Disease (Tuberculosis)	Known to us since 8/21/46

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.: ———

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of: ———

Where did injury occur? (City or town) (County) (State) ———

Injured at home, farm, industry, public place (where?):

Means of injury: ——— Injured at work? ———

23. SIGNATURE: Albert J. Armstrong M. D. or other

Address: Crownsville, Maryland Date signed: 9/14/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

08721

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Crownsville State Hosp.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 2 years 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1823 Eutaw Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: Nadine Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Charles Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9, 1915

8. AGE: Years	Months	Days	If less than one day
31	2	13	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: E. E. Westcott
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Johnson
15. Birthplace: Md
16. Informant: Hospital Records
Address: Crownsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 25-46 (month) (day) (year)
Cemetery or crematory: Arlington
Location: Baltimore County.
18. Funeral director: Rev. G. Kelson
Address: 1303 Freeman St.
19. 9/23/46 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 19 46 at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 19 44 to Sept 22 19 46 and that I last saw h.. alive on Sept. 22 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions: Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Wm. L. Hamilton M.D. M. D. or other
Address: ..... Date signed .....

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

08722

Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Davidsonville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 yrs

Hospital, Institution, or street address where death occurred: Davidsonville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Davidsonville, (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural Davidsonville P.O. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LOUISA KING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George King

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19, 1862

8. AGE: Years	Months	Days	If less than one day
84	3	29	..... hrs. ..... min.

9. Birthplace: Davidsonville, A.A. Co. Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: --- ----

FATHER — 12. Name: Benjamin Ireland

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: J. Irving King

Address: Davidsonville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21. 46 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping & Son

Address: 170-172 West St. Annapolis, Maryland

19. Sept. 19 1946 (Date rec'd by registrar) Received - Sept 21 - 46 Carrie Shutt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1946 at 11.00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept. 17 1946 and that I last saw her alive on Sept. 17 1946

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Hypostatic pneumonia	
Due to: Gastric carcinoma	
Other conditions: Hypertensive cardiovascular disease. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward P. Ritchings, M.D. M. D. or other

Address: Annapolis, Md. Date signed: Sept. 19, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

08723

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Wilentown, Odenton P.O. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 10 minutes
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Wilentown, Odenton R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. as above
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Annie E. Larkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: Horace A. Larkins
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years: 61 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Annapolis A.A.C., Maryland
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Home
FATHER 12. Name: Charles Green
13. Birthplace: Annapolis Md
MOTHER 14. Maiden name: unknown
15. Birthplace
16. Informant: Horace A. Larkins
Address: Wilentown, Odenton R.F.D., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2-46 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis A.A. Co Md
18. Funeral director: Martin Flading & Sons
Address: Bowie Md.
19. Oct. 2 1946 Mrs. J.W. Yingling Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1946, at 12 noon M.
21. I CERTIFY that death occurred on the date above stated; ~~and that deceased was last attended by me on~~ Post Mortem Examination Sept. 29, 1946

	DURATION
Immediate cause of death	
Acute Dilatation of Heart	sudden
Due to Chronic endocarditis	
and arterial hypertension	uncertain
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Getty M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 9/29/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

08724

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: RURAL, MAYFIELD - ODENTON, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: BETSON AVENUE
Stay in hospital or inst. (yrs., or mos., or days): 18 DAYS - JULY-AUG 1946
Stay in this community (yrs., or mos., or days): LIFE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ANNE ARUNDEL
City or town: RURAL - NEAR ODENTON Ward No. FOURTH DISTRICT
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: RURAL — BETSON AVE
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: NELSON LOWMAN

3. (b) Social Security Number: 215-12-3807

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: LOLA ESTELLE LOWMAN
6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): JANUARY 18, 1900

8. AGE:

Years	Months	Days	If less than one day
46	7	30	____ hrs. ____ min.

9. Birthplace: ODENTON, MARYLAND.
(Town, county, and state)
10. Usual occupation: ELECTRICIAN.
11. Industry or business: MAINTENANCE, REPAIR ELECTRICAL WORKS.

FATHER
12. Name: MATTHIAS LOWMAN
13. Birthplace: ODENTON, MARYLAND

MOTHER
14. Maiden name: ISABELL REDMILES
15. Birthplace: BOWIE, MD.

16. Informant: MRS. LOLA LOWMAN
Address: MAYFIELD, ODENTON MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1946. (month) (day) (year)
Cemetery or crematory: Epiphany Church Yd
Location: Odenton Md
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md

19. 9/18 1946 (Date rec'd by registrar) Registrar: M. DeAlba

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 17 1946, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 23 1946, to SEPT 17 1946, and that I last saw him alive on SEPT 16 1946.

	DURATION
Immediate cause of death: CARDIO-RESPIRATORY FAILURE	
Due to: CARDIAC DECOMPENSATION	
Due to: MALIGNANT HYPERTENSION	10 MONTHS.
Other conditions: DIFFUSE PENDANT, PITTING EDEMA, PASSIVE CONGESTION OF LIVER	4 MONTHS

(Include pregnancy within 3 months of death)

Major findings:
Of operations: NONE PERFORMED.
Of autopsy: NONE PERFORMED.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Henry F. Langan, M.D.
M. D. or other
Address: Glen Burnie Date signed: Sept 17, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08725

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred: 1208 Bay Ridge Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)

Street No. 1208 Bay Ridge Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dr George Taylor MASTERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Henretta G. Masters

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1883

8. AGE: Years: 62 Months: 10 Days: 29 If less than one day: hrs. min.

9. Birthplace: Marksville, La. (Town, county, and state)

10. Usual occupation: Dentest D.D.S

11. Industry or business

FATHER 12. Name: Nicholas Masters

13. Birthplace: Unknown

MOTHER 14. Maiden name: Rosalie Garrot

15. Birthplace: Unknown

16. Informant: Mrs Henretta G. Masters

Address: 1208 Bay Ridge Ave Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Maryland

18. Funeral director: B.L. Hopping & Son

Address: 170-172 West St. Annapolis, Md

19. Sept. 10 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1946, at 4:9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 8 1946 and that I last saw h... alive on Sept 8 1946

Immediate cause of death	DURATION
Coronary Thrombosis	8 days
Due to	
Due to	
Other conditions Arteria - Sclerosis	Infan...

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Boyd M. D. or other

Address: Annapolis Md Date signed 9-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

087256

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town (If outside city or town limits, write RURAL and give nearest town) Brooklyn Jct Route 9.
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Brooklyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Light St Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Theadore Metzke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband or wife Pauline Walthke
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) June 6th 1865

8. AGE: Years 81 Months Days If less than one day ....hrs. ....min.

9. Birthplace Danzig Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Martin Metzke
13. Birthplace Germany

MOTHER
14. Maiden name Julia Bleatman
15. Birthplace Germany

16. Informant Mrs. Elsie Bibley
Address Light St Rd

17. Burial Date thereof 9/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Md.

18. Funeral director John F Denny Inc
Address 76 Light St.

19. 9-16 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13-46 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15-46 19.. to Sept 13-46 19.. and that I last saw h.. alive on Sept 12-46 19..

	DURATION
Immediate cause of death Acute Bronchopneumonia	5 day
Due to	
Due to Carcinoma Colon	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm G Metzke M.D. or other
Address Edenton Date Signed Sept 13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08727

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Defense Highway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Defense Highway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry W. Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katie G. Miller
6.(c) If alive give age: years

7. Birth date of deceased (mo., day, yr.): June 16th 1880

8. AGE: Years: 66 Months: 2 Days: 16 If less than one day: hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Harry Miller
13. Birthplace: A. A. Co. Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Arnold H. Miller
Address: South River Road A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9th 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John W. Taylor Sons
Address: Annapolis Md.

19. Sept. 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1946, at 1 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2 1944, to Sept 2 1946
and that I last saw h... alive on Sept 2 1946

Immediate cause of death	DURATION
acute dilatation of heart	10 hrs
Due to arteriosclerotic - cardio - vasal cardiac disease	10 yrs (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Bozeman M.D. (M. D. or other)
Address: Annapolis Md. Date signed: 9/3/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

08728

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County:

City or town: Brookhaven
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4108 Edgemont Aveune
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: JOSEPH C. NEWSOME

3. (b) Social Security Number: 33 985 774

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna L. Newsome

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 25 August, 1915

8. AGE: Years	Months	Days	If less than one day
31	0	26	hrs. min.

9. Birthplace: Chester, Pennsylvania
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business:

FATHER — 12. Name: Joseph H. Newsome

13. Birthplace:

MOTHER — 14. Maiden name: Almond H. Newsome

15. Birthplace:

16. Informant: U. S. Army Service Record

Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/22/46 (month) (day) (year)

Cemetery or crematory: Marshall Bros. Undertakers

Location: Chester, Pa.

18. Funeral director: Howard N. Blight Jr.

Address: 4914 Belair Road, Baltimore, Md.

19. 21 Sept. 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., MC Registrar

Bernard F Kerwin

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 September 1946, at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on not seen alive 19

Immediate cause of death: Coronary occlusion — DURATION: 1-2 hrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Verified diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Carleton S. Herrick Jr.
CARLETON S. HERRICK, JR. M. D. or other

Address: Ft Geo G Meade Md 1st Lt Date signed 22 Sept 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 84a

CERTIFICATE OF DEATH

Reg. Dist. No. 087228

1. PLACE OF DEATH: Crownsville State Hosp.
County A. A.
City or town Crownsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since Nov 3rd, 1944.
Hospital, Institution, or street address where death occurred: Crownsville State Hosp.
How long in hospital or institution? since Nov. 3rd, 1944.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Stephensville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: CONSTANCE NICKERSON (NIXON)

3. (b) Social Security Number

4. Sex: fem.
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: Stepmother Ella Nickerson, Stephensville
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 17 | Months 10 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: unknown
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace
MOTHER 14. Maiden name: unknown
15. Birthplace
16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-46 (month) (day) (year)
Cemetery or crematory Hospital
Location Crownsville Md.
18. Funeral director Supt.
Address Crownsville
19. Rec'd (Date rec'd by registrar) 19 44 E. T. Boyle Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 1946 19 46 at 7,30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3rd, 1944 19 44 to Sept. 17 19 44
and that I last saw her alive on Sept. 16, 1946 19 46

	DURATION
Immediate cause of death: Exhaustion	
Due to: Congenital Idiocy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Hans Steiner M.D.
M.D. or other
Address Crownsville State Hospital Date signed Sept. 17, 46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08730

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: THOMAS NOVAK

3. (b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marie Novak
6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): December ? 1865

8. AGE: Years	Months	Days	If less than one day
80	8		hrs. min.

9. Birthplace: Austria
(Town, county, and state)
10. Usual occupation: laborer (retired)
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace: Austria
MOTHER 14. Maiden name: " " " "
15. Birthplace: " " " "
16. Informant: Frank T. Novak
Address: P. O. Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 7, 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Balto., Md.
18. Funeral director: Jerome Cvach
Address: 900 N. Chester st. Balto.
19. 9-5 1946 (Date rec'd by registrar) L. A. Breir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1946, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1939 to Sept. 5 1946 and that I last saw him alive on Sept. 4 1946

Immediate cause of death	DURATION
Pulmonary edema	1 day
Cerebral hamorrhage	2 days
Due to Arteriosclerosis	indef.
Due to Arteriosclerotic heart disease." "	
Due to (congestive heart failure	4 wks.)
Other conditions Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. A. Breir M. D.
Address: Pasadena, Md. M. D. or other
Date signed: 9-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08731

CERTIFICATE OF DEATH

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: PERKINS - LAURA

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1896? 1906?

8. AGE: Years	Months	Days	If less than one day
40? 50?	unknown		——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ———

FATHER
12. Name: Augustus Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ida Wallace
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1946 (month) (day) (year)
Cemetery or crematory: Norbeck
Location: Montgomery County

18. Funeral director: Robert L. Snowden
Address: Rockville, Maryland

19. Sept 25 1946 (Date received by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1946, at 11:40A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1946, to Sept. 24 1946 and that I last saw her alive on September 24 1946

Immediate cause of death	DURATION
General Paresis	Known to us since 9/5/46
Due to: ———	
Due to: ———	
Other conditions	

(Include pregnancy within 3 months of death) ———

Major findings of operations: ——— Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ——— ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Herbert J. Brookes M. D. or other
Address: Crownsville, Maryland Date signed: 9/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-B)

CERTIFICATE OF DEATH

08732

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Severn Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Pernot (or Purnot)

3.(b) Social Security Number: 218-14-4355

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

8.(b) Name of husband or wife: —
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business

FATHER — 12. Name: Unknown; 13. Birthplace:

MOTHER — 14. Maiden name: Unknown; 15. Birthplace:

16. Informant: Record at Police Station
Address: Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis Md.
19. Sept 28, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1946, at 11 45 A. M.
21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ from Postmortem Examination - as ~~[illegible]~~ alive as Sept. 28 1946

Immediate cause of death	DURATION
Due to: Suicide by drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Probably
Accident, suicide, or homicide? Suicide Date of 9-26-46
Where did injury occur? Eastport (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Spa Creek
Means of injury drowning Injured at work? No

23. SIGNATURE: John M. Clapp, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 9/28/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

08733

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs, 10 mos, 25 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 8 yrs, 10 mos, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?? Hillon Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME

PURNELL - TILLIE

3.(b) Social Security Number

---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.): 1884?

8. AGE: Years: 62? Months: unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laundry Work

11. Industry or business: ----

FATHER
12. Name: Stewart Purnell
13. Birthplace: unknown

MOTHER
14. Maiden name: Maria ?
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address: Crownsville Md

19. Oct 1 (Date rec'd by registrar) 1946 E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1946, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 1937, to Sept. 15 1946 and that I last saw her alive on September 15 1946

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 10/20/37
Due to: -----	
Due to: -----	
Other conditions: Senile Psychosis	Known to us since 10/20/37

(Include pregnancy within 3 months of death)

Major findings of operation: ------ Date of op.: ----

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: -----

Where did injury occur? ---------
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ------ Injured at work? ---------

23. SIGNATURE: Ward V. Woodcock M. D. or other

Address: Crownsville, Maryland Date signed: 9/15/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MSd

CERTIFICATE OF DEATH

08734 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Defense Highway.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Elwood Robert Reese

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1946.

8. AGE: Years	Months	Days	If less than one day
1		27	hrs. min.

9. Birthplace: Washington, District of Columbia (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Claude Elwood Reese Jr
13. Birthplace: Berwyn, Maryland.

MOTHER
14. Maiden name: Bernice Mary Richardson
15. Birthplace: Providence, Rhode Island

16. Informant: Mrs. Bernice M. Reese
Address: Defense Highway, Gambrills P.O., Md

17. Burial, cremation, or removal. Which?: Removal. Date thereof: Sept 3, 1946. (Month) (day) (year)
Cemetery or crematory: Hyattsville Md.
Location: Maryland.
18. Funeral director: F. Gaschi Sons
Address: Hyattsville Md.

19. 9-3-1946 (Date rec'd by registrar) Carrie Hunt, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 1946, at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~last attended deceased from~~ Post mortem Examination ~~and last saw deceased on~~ Sept. 3, 1946

Immediate cause of death	DURATION
Suffocated	
Due to: Inspiration of milk into trachea during a vomiting spasm.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy? Results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 9-3-46
Where did injury occur? near Gambrills, A. A. Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: vomited milk Injured at work?

23. SIGNATURE: John M. Claffy M. D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

08735 P

Reg. Diat. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2300 N. Fulton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME WALTER MARCUS ROGERS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Bessie F. Rogers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 11, 1884

8. AGE: Years	Months	Days	If less than one day
62	5	13	..... hrs. ..... min.

9. Birthplace Newark, N. J.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Charles W. Rogers
13. Birthplace N. J.

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr. Walter F. Rogers
Address Box 114, Benson, Ariz.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/46 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 9/27/46 (Date rec'd by registrar) 19.....

A. W. Heaver
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 19 46, at 730 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 46 to Sept 21 19 46 and that I last saw h.im alive on Sept. 23 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arteriosclerosis	Unknown
Due to	
Other conditions Myocarditis Chr.	Unknown

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bond M. D. or other

Address Annapolis Md Date signed 9-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08736

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. Co.

City or town BROOKLYN PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County .....

City or town BROOKLYN PARK.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 - 2nd Ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME CHARLES M. RUDD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife ELIZABETH RUDD

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 16 1867

8. AGE: Years	Months	Days	If less than one day
79	5	25	.....hrs. .....min.

9. Birthplace VA (Town, county, and state)

10. Usual occupation RETIRED PAINTER

11. Industry or business

FATHER 12. Name CHARLES RUDD

13. Birthplace VA

MOTHER 14. Maiden name ?

15. Birthplace VA

16. Informant MRS R. C. GREASER

Address 18-2nd AVE BROOKLYN PARK.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT 14- 46 (month) (day) (year)

Cemetery or crematory MT MARIE CEM

Location TOWSON MD

18. Funeral director Bernard E Harle

Address 121 E West St

19. 9-13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11th 1946, at 7 15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/11 1946, to 9/11/46 19.....

and that I last saw b- alive on 9/11/46 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel Rudd M. D. or other

Address 203 Patapsco ave Date signed .....

08737

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: South River (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mounths

Hospital, institution, or street address where death occurred: summer home at south river

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis, (If outside city or town limits, write RURAL and give nearest town)

Street No. 138 Monticello Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SLAMA: Anthony

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Anna P. Slama

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): April 1, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	0	..... hrs. ..... min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)

10. Usual occupation: Owener of Shoe store

11. Industry or business

FATHER — 12. Name: Frank Slama

FATHER — 13. Birthplace: Bohemia

MOTHER — 14. Maiden name: Anna Chat

MOTHER — 15. Birthplace: Bohemia

16. Informant: Mrs Anna P. Slama

Address: 138 Monticello Ave. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping & Son

Address: 170-172 West St. Annapolis, Maryland

19. Sept. 3 1946 (Date rec'd by registrar) Edward Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1946, at 3 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 30, 1946, to SEPT. 1, 1946 and that I last saw h. I.M. alive on SEPT. 1, 1946

Immediate cause of death	DURATION
Coronary Occlusion	3 days.
Due to: Cardiac insufficiency	8 yrs.
Due to: Cardio-Vascular Renal Disease	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: James R. Martin, M.D. M. D. or other

Address: 1 E. King George St. Annapolis, Md. Date signed: 9-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

NAME: Dr. Claffy's authorization of 10-28-46 filmed GLORG - LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08740

Reg. Diat. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hours
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John Frederick (STEVENS) Smith, Jr.

3.(b) Social Security Number 219-18-0158

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1923

8. AGE:

Years	Months	Days	If less than one day
22	11	30	hrs. min.

9. Birthplace: Bowie, Prince Geo. Co., Maryland
(Town, county, and state)
10. Usual occupation: labor
11. Industry or business: cinder - block

FATHER
12. Name: John Frederick (STEVENS) Smith, Sr
13. Birthplace: Dover, Delaware

MOTHER
14. Maiden name: Martha E. Irving
15. Birthplace: Nottingham, Maryland.

16. Informant: Albert Newton Smith
Address: Bowie, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 5 1946 (month) (day) (year)
Cemetery or crematory: Perkins Chapel
Location: Springfield Md

18. Funeral director: Clarence Forecare
Address: Mitchell Ville Md

19. 9-3-46 (Date rec'd by registrar) Carrie Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1946 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19 ~~and last saw alive on~~ Sept. 3, 1946

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9-2-46
Where did injury occur? Near Riva (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): South River
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 9/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08738

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: G. G. C.

County

City or town (If outside city or town limits, write RURAL and give nearest town) Cypris Creek, Severna Park, Md.

How long in above place of death? 1&1/2 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town (If outside city or town limits, write RURAL and give nearest town) Cypress Creek, Severna Park

Street No. Harwood Developement (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Cullen Ira Speers

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Margaret Speers Nee Hoffman 6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) October 25, 1880

8. AGE: Years	Months	Days	If less than one day
65	11	1	hrs. min.

9. Birthplace: Sunbury, Pa. (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Curtis Bay Coal Pier B&O RR

FATHER — 12. Name: Ira Waters Speers

13. Birthplace: Michigan

MOTHER — 14. Maiden name: Clementine Leister

15. Birthplace: Mt. Airy, Md.

16. Informant: Mrs. Mary Margaret Speers

Address: Cypress Creek, Severna Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30, 46 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Homer W. Dugdale

Address: Glen Burnie, Md.

19. Sept 30 1946 (Date rec'd by registrar) M. Balbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1946, at 5 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from March 21, 1946 to Sept. 26, 1946 and that I last saw h... alive on September 26 1946

Immediate cause of death	DURATION
Acute dilatation of the Heart	Minutes
Due to: 1) Arteriosclerotic Cardio-	
Due to: Vascular Disease	Since 3/21/46
Other conditions: Obstructive Jaundice (Cause Unknown)	Since 3/21/46

(Include pregnancy within 3 months of death)

Major findings of operations: (None)

Date of op.

Autopsy results: (None)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed 9/30/46

H. J. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

08739

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town (Rural) St. Margarets Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town St. Margarets Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hemmia Stansbury

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife Isaac Stansbury

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25 1880.

8. AGE: Years	Months	Days	If less than one day
65	11	2	hrs. min.

9. Birthplace St. Margarets U.S.A. Co. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name William Chambers

13. Birthplace Md.

MOTHER 14. Maiden name Margrett Carroll

15. Birthplace Md

16. Informant Charles Stansbury

Address R. F. D. # 2. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30 '46 (month) (day) (year)

Cemetery or crematory Broadneck

Location Skidmore Md

18. Funeral director J.B. Johnson

Address Annapolis

19. Sept. 30 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1946 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944 to Sept 27, 1946

and that I last saw him alive on 19

Immediate cause of death	DURATION
Hypertensive - Cardio Vascular Disease	2 yrs
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.B. Johnson M. D.
M. D. or other

Address 60 Northwest Street Date signed 9/29/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-51)

08741

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Solley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Solley
(If outside city or town limits, write RURAL and give nearest town)
Street No. (Glen Burnie P.O.,) rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Reuben Taylor

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Georgiana Taylor
6.(c) If alive, give age: 80 years
7. Birth date of deceased (mo., day, yr.): Mar. 1864
8. AGE: Years: 82 Months: Days: If less than one day: hrs. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farming (General)
FATHER 12. Name: Samuel Taylor
13. Birthplace: Virginia
MOTHER 14. Maiden name: not known
15. Birthplace:
16. Informant: Viola E. Jacobs
Address: Glen Burnie P.O. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-19-46 (month) (day) (year)
Cemetery or crematory: Magothy
Location: Jacobsville, C. A. Co.
18. Funeral director: William A. Jackson
Address: 916 Penna. Ave. Balto. 1, Md.
19. 9/19 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 19 46 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated, ~~that I attended deceased from~~ Postmortem Examination
~~and that I last saw him on~~ Sept. 16 19 46

	DURATION
Immediate cause of death	
Due to: Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	1 Year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Clagett M.D. M. D. or other Deputy Medical Examiner
Address: Annapolis, Md. Date signed 9/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-d)

CERTIFICATE OF DEATH

08742
Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 18 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1033 North Mount Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: VEENEY - KENNARD

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE:	Years	Months	Days	If less than one day
	56	unknown	---	--- hrs. --- min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: Richard Veeney
13. Birthplace: Virginia
MOTHER 14. Maiden name: Primrose ?
15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Buried (Burial, cremation, or removal) Date thereof: Sept. 20, 1946 (month) (day) (year)
Cemetery or crematory: W.P. Calvary cem
Location: Baltimore City
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St., Balto., Md.
19. 9-18-46 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 19 46 at 11:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 19 46 to Sept. 17 19 46 and that I last saw him alive on September 17 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 6/29/46
Due to: -----	
Due to: -----	
Other conditions: Involutional Psychosis - Melancholia (Include pregnancy within 3 months of death)	Known to us since 6/29/46

Major findings of operations: -------
Date of op.: -----
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: -------
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: --------- Injured at work? -------

23. SIGNATURE: Albert L. Armfield M. D. or other
Address: Crownsville, Maryland Date signed: 9/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

08743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Garland Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Garland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 321 Orchard Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Fannie Wagner
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles M. Wagner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 14 - 1861

8. AGE: Years 85 | Months 7 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Harford Co. Maryland (town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Wm. Benjamin Preston
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia
15. Birthplace: Maryland

16. Informant: Howard M. Wagner
Address: Garland Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28. 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road

19. 9/28 1946 A. W. Heduck Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26. 1946 at 10-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20/46 1946 to 9/26/46 1946
and that I last saw h.. alive on 9/25/46 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to: Hypertension	?
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

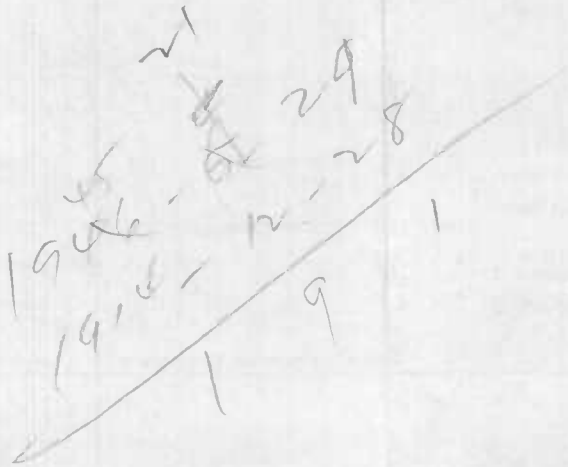
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Constance H. Parker M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed: 9/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93 (d)

CERTIFICATE OF DEATH

08744 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1017 Jackson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1017 Jackson Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH H. WATKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Sydne Watkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21st 1861

8. AGE: Years	Months	Days	If less than one day
85	5	16	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: William Graham
13. Birthplace: Virginia

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: William C. Winder
Address: Eastport - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10th '46 (Month) (day) (year)
Cemetery or crematory: Elmwood Cemetery
Location: Norfolk, Virginia
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Sept. 8, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-7- 1946, at 2.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-22- 1946, to 9-7- 1946 and that I last saw h.. alive on 9-7- 1946

	DURATION
Immediate cause of death: Coronary occlusion	5 days
Due to: Arteriosclerotic Heart Disease	20 yrs.
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: James R. Martin, M.D.
M. D. or other
Address: 165 Prince George St Annapolis Md. Date signed: 9-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

CERTIFICATE OF DEATH

(★) 08745 Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several hours
Hospital, institution, or street address where death occurred: near Carr's Wharf, Rhodes River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis, R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 North Glen Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chester J. Whitten - Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Aubrey L. Whitten
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 4 - 1906

8. AGE:

Years	Months	Days	If less than one day
40	7	23	hrs. min.

9. Birthplace: Amherst Va (Town, county, and state)
10. Usual occupation: Linesman for
11. Industry or business: Pub. Electric Co.

FATHER
12. Name: John W. Whitten
13. Birthplace: Va

MOTHER
14. Maiden name: Rebecca Smoot
15. Birthplace: Va

16. Informant: Aubrey L. Whitten
Address: 19 N. Glen Ave Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30th 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie Md.

18. Funeral director: John M. Sayler & Son
Address: Annapolis Md.

19. Sept 28 1946 (Date rec'd by registrar) Chas. E. Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 1946, at 2 30 P.M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Sept. 27. 1946

Immediate cause of death	DURATION
Electrocution	
Due to: 2400 volts	
Due to: Accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9/27/46
Where did injury occur? near Mayo (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Carr's Wharf Rd. and Fennaborn Rd.
Means of injury: 2400 Volts Electricity Injured at work? yes

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis, Md. Date signed: 9/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: a. a.
(a) ~~Baltimore City~~, Maryland
(b) Street address 102 Seventh Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a. a 18746
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Seventh Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Van Wickelen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Estelle M. White

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) October 24, 1864

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Construction Foreman

11. Industry or business Chemical Co.

FATHER
12. Name John Wickelen
13. Birthplace New York

MOTHER
14. Maiden Name Tucker
15. Birthplace New York

16 (a) Informant Mrs Estelle Van Wickelen
(b) Address 102 Seventh Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/16/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Heyney Inc
(b) Address 714 Light St.

19 (a) (Date rec'd by registrar) **(b)** Registrar

SEP 16 1946 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1945 to Sept. 13 1946, and that I last saw h[illegible] alive on Sept. 13 1946.

	Duration
Immediate cause of death Broncho – pneumonia (hypostatic)	3 wks
Due to	
Due to	
Other Conditions Hypertensive cardio vascular renal disease (Include pregnancy within 3 months of death)	11 mos.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.
Address 1226 Hanover St. Date signed 9/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

08747

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 422 Third Ave. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Herman W. Wilks

3.(b) Social Security Number: 218 01 0854

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Augusta K Wilks
Nee: Graefe
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): July 1, 1902

8. AGE: Years	Months	Days	If less than one day
44	2	6	..... hrs. ..... min.

9. Birthplace: Glen Burnie, Md. (Town, county, and state)
10. Usual occupation: Contractor & Builder
11. Industry or business

FATHER
12. Name: Frederick Wilks
13. Birthplace: Germany

MOTHER
14. Maiden name: Hulda Reinhardt
15. Birthplace: Germany

16. Informant: Mrs. Herman W. Wilks
Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10, 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. Sept 10 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1946, at 6.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946, to Sept. 7 1946
and that I last saw h~~im~~ alive on 9/7/46 1946

Immediate cause of death	DURATION
Mitral Insufficiency	7 months
Due to Interstitial nephritis	7 "
Due to Diabetes	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave A Baumbrud M. D. or other
Address: Glen Burnie Md Date signed 9/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

File No. 08748 Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's County

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

WILSON - JAMES HENRY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Marie Wilson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Unknown 1879

8. AGE: Years	Months	Days	If less than one day
67 ?	?	?	...hrs. ...min.

9. Birthplace: Virginia ?
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: [illegible]

13. Birthplace: "

MOTHER 14. Maiden name: "

15. Birthplace: "

16. Informant: Hospital records

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 14, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olive

Location: Bladensburg Rd., Maryland

18. Funeral director: J. B. Johnson [illegible]

Address: Annapolis, Maryland [illegible]

19. 9/12-46 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10, 1946, at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1946, to September 10, 1946 and that I last saw him alive on September 10, 1946

Immediate cause of death	DURATION
General Arteriosclerosis (Apoplexy)	Known since admission
Due to: ———	
Due to: ———	
Other conditions: ———	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work ———

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 9/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

118749

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 16 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Spencerville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: WILSON - DARAH

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
46	unknown		---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Lavinia Wilson ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1946 (month) (day) (year)

Cemetery or crematory: Good Hope Cemetery

Location: Colesville, Maryland

18. Funeral director: Robert L. Snowden, Maryland

Address: Rockville, Maryland

19. 9/16 46 (Date rec'd by registrar) E. Joyce Pocal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1946, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1946, to Sept. 15 1946 and that I last saw her alive on September 15 1946

Immediate cause of death	DURATION
General Paresis	Known to us since 7/29/46
Due to: ----	
Due to: ----	
Other conditions: ----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: Robert L. Snowden M. D. or other

Address: Crownsville, Maryland Date signed: 9/15/46

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

08750

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four Days
Hospital, Institution, or street address where death occurred: Army Area Regional Station Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? Four Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1036 N. Eutaw Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: ANNAN N. WOODYARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 October, 1924

8. AGE: Years	Months	Days	If less than one day
21	10	10	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business: -

FATHER
12. Name: Earl Brown
13. Birthplace: Philadelphia, Pennsylvania

MOTHER
14. Maiden name: Mary Woodyard
15. Birthplace: Baltimore, Maryland

16. Informant: Mary Woodyard (Mother)
Address: 1036 N. Eutaw Street, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 September 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore City

18. Funeral director: Charles R. Law
Address: 802 Madison Avenue, Baltimore, Md.

19. 3 September 1946 (Date rec'd by registrar) Bernard F. Kerwin (Registrar)
BERNARD F. KERWIN, Capt.
MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 September, 1946 at 0750 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Sept. 1946 to 3 Sept 1946 and that I last saw h. alive on 3 Sept 1946

Immediate cause of death	DURATION
Shock resulting from burns	
Due to: 65% burn incurred in automobile accident.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 30 Aug. 1946
Where did injury occur? Near Baltimore, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public Road
Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: Alexander Storer Jr., Capt MC (M. D. or other)
Address: Ft. Meade Regional Hospital Date signed: 9 Sept 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

08715

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 13 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or Institution? 11 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 814 Edmondson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Young Harry

3. (b) Social Security Number: .....

4. Sex: M.
5. Color or race: B.
6. (a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years: 55 Months: — Days: — If less than one day: ... hrs. ... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: .....

FATHER
12. Name: Jimmy Young
13. Birthplace: Md.

MOTHER
14. Maiden name: Mathilda Parr
15. Birthplace: Md

16. Informant: Hospital records
Address: Crownsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24-46 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore City
18. Funeral director: Geo. E. Kelson
Address: 1303 Presstman St.

19. 9/23/46 (Date rec'd by registrar) 19..... A. W. Jedrus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22nd 19 46, at 2:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5th 19 45, to Sept. 22 19 46
and that I last saw him alive on September 22 19 46

Immediate cause of death: General Paresis — DURATION: known to me since admission

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Albert V. Winstead M. D. or other
Address ..... Date signed .....